

# WHY SAFE LEGALISED VOLUNTARY EUTHANASIA IS A MYTH

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THE CRIMINAL LAW in Australia holds that the intentional taking of human life is a major criminal offence. This accords with the United Nations Universal Declaration of Human Rights, to which Australia is a signatory, which declares that the right to the integrity of every person's life is equal, inherent, inviolable, inalienable and should be protected by law.

Since the intentional taking of human life is the specific aim of every euthanasia law, such a law would be unique in the following critically important ways:

- it would intend to subvert the existing law
- it would fail to respect the principle that all are equal before the law
- it would fail to respect the principle that all human lives have equal value, and
- it would attempt to gain legal recognition for the concept of life not worth living.

This would present an impossible task, if honesty were to prevail. It would have to rely on such things as asserted but non-existent human rights, shades of deceit, inexact definitions and words or clauses allowing loose interpretations, rather than objectivity and precision.

The push for legalised medically assisted death in Australia has now increased to the point where bills are before several state parliaments and another is before the Commonwealth parliament to reverse the previous overturning of the Northern Territory legislation. I have analysed most of the previous failed bills and noted their weaknesses. Rather than debate the pros and cons of the social role of euthanasia, I believe that MPs, who have sole responsibility for making *safe* laws, should direct their attention to ensuring that draft euthanasia bills cannot imperil the lives of innocent people who do not wish to die.

It is evident that the authors of those bills have not read any of the extensive literature on this subject because they invariably include, as so-called safeguards,

provisions which are known not to work in practice. A common feature of those who advocate euthanasia bills is their touching faith that certain things will happen, just because the draft prescribes them. If that were true, no crime would ever be committed because all crime is currently forbidden by some law.

## SOCIETY

In 1958, Yale Kamisar, an American professor of law in this field, wrote a seminal paper in which he listed these basic difficulties: ensuring that the person's choice was free and adequately informed; physician error or abuse; difficult relationships between patients and their families and between doctors and their patients; difficulty in quarantining voluntary euthanasia from non-voluntary; and risks resulting from this overt breach of the traditional universal law protecting all innocent human life. All these problems still exist and others have been added, such as the critical role of depression in decision-making and the evolution in the moral basis for requesting death from the relief of severe suffering in the terminally ill to reliance on respect for personal autonomy. Some of these will be discussed below.

Definitions are often vague or at odds with ordinary meanings. For example, in place of "terminal illness" one may find "incurable illness". Many illnesses are literally incurable but do not necessarily cause death or shorten life. Pain and suffering are both highly subjective experiences; neither can be measured or compared between persons, while suffering is often due to social causes rather than medical. According to the drafts, both have to be simply accepted as the person describes them, even when this may raise serious doubt. And, as most now allow, if the symptoms are said to make life "intolerable", even though it is recognised that what one person finds intolerable others can bear, that claim has only to be made to be incontestable. The situation then will have become virtually one of death on demand.

All bills require the doctor to be "satisfied" that

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the patient's request was freely made, though no one could ever know with certainty about coercion from sources of which he was totally unaware. But would coercion be likely? Brian Burdekin, a former Human Rights Commissioner, reported that in his experience, "The most vulnerable were the most likely to be abused and the most likely to be coerced." Subtle degrees of coercion would be almost impossible to detect.

If a well person asks for death he will be referred for counselling. If a sick person asks, he is as likely to be supported in his "exercise of personal autonomy". And what of autonomy in the presence of severe illness, especially terminal illness, with its frequent association with depression and unrelieved pain, which powerfully hinder careful evaluation of issues? More importantly, no matter what the patient decides, in every case it will be the doctor's decision that determines whether euthanasia actually proceeds. Leon Kass, a lawyer and prolific author in this area, wrote that, in view of the totality of the impediments to clear reasoning in such patients, "the ideal of rational autonomy, so beloved of bioethicists and legal theorists, rarely obtains in actual medical practice".

Doctors are experienced in persuading patients to follow their legitimate advice concerning treatment options, to the point where some have been heard to say, "I can get my patients to do anything I want." Their power, relative to that of the patient, is large even when there is no intention to manipulate. Euthanasia draft bills require doctors to inform patients about the medical details of their illness and future alternatives. Since such discussions will usually occur in private, one could never know whether such information was accurate, adequate, non-coercive and impartial. If the doctor's personal view was that euthanasia was appropriate for a patient, we may be sure some would not be deterred from advocating it.

**A** LOT OF PUBLICITY has lately been given to the fact that some 85 per cent of respondents to opinion polls favour legalised euthanasia. This refers to the Morgan poll which has been using this question for many years: "If a hopelessly ill patient in great pain with absolutely no chance of recovering asks for a lethal dose, so as not to wake again, should the doctor be allowed to give the lethal dose or not?" It is not hard to see why many respondents, whose understanding of the complex matter of euthanasia is unknown, might agree to such

an emotionally charged question. Given that repeated polls have shown that most Australian doctors have not received adequate training in palliative care, and sometimes none at all, should anyone be surprised that too often pain is poorly managed? Against that background, the poll question may be truthfully reworded, "If a doctor is so negligent as to leave his patient in pain, severe enough to drive him to ask to be killed, should the doctor be able to compound his negligence by killing the patient, instead of seeking expert help?" The community would be appalled to know how few doctors who must care for dying patients are able to deal with severe pain effectively. The only remedy for

this situation will be to introduce mandatory levels of competence in palliative care training in all medical schools. In the meantime, legalising euthanasia will lead inevitably to many needless deaths. Australia has about half the palliative care specialists it needs, all of whom are in cities or big towns.

Too often, draft bills for euthanasia only require the doctor to obtain expert psychiatric advice if he "suspects" the patient is "not of sound mind", that is, has impairment of competence, which is not the key issue. The literature of psychiatry contains abundant evidence that the sustained wish to die is associated, in a large number of the seriously ill, with depression, which alters mood and inhibits the ability to reason coherently. Not to require consultation by a psychiatrist experienced in the treatment of dying

patients whenever a sustained wish to die is encountered, is a negligent omission, especially as such depression is often difficult to diagnose. A published retrospective review of the Northern Territory legislation in its short life showed that relevant psychiatric evidence had been withheld and treatable depression was missed in four of the seven patients whose lives were taken under its provisions. The demoralising combination of depression or despair, anxiety and fear associated with a desire to die, can usually be treated with a mix of empathy, psychotherapy and medication.

The usual superficial approach to this problem is in stark contrast to the following advice from expert psychiatrists: "No request for hastened death can be understood without first attempting to understand the psychological landscape within which the request arises." One advised, "Never kill yourself when you are suicidal—you are not yourself then." Accordingly, it has been suggested that the need for better training in the detection of profound psychological disturbance in

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these patients is as great as that for the relief of severe pain. Even in the Netherlands, there is awareness of past failings, as the former health minister from 1994 to 2002, Mrs Borst-Eilers, commented in 2009, "The government's move [to legalise euthanasia] was a mistake, we should have first focused on palliative care."

**W**HEREVER VOLUNTARY EUTHANASIA is practised, legally or not, non-voluntary is also found, including in Australia. Many find this difficult to credit because, whatever their failings, doctors surely would not take life without any request. In fact, they do it because it seems logical. Once euthanasia for patients who are suffering and ask to be killed is regarded as providing them with a benefit, it will appear, at least to some, that it would be wrong to withhold that benefit from others who suffer as much, but who, for some reason, cannot ask. In their eyes, this would be a matter of compassion. Because the same rationale can be the justification for euthanasia for both groups, the extension of one to the other must be regarded as inevitable and so will be uncontrollable. The Dutch have long since given up trying to prevent non-voluntary euthanasia.

Bills require the doctor to notify the coroner, following euthanasia. Since he will be its sole author, the chief actor and the sole survivor of the event, what chance is there that the doctor will include anything he would not wish the coroner to know?

Some may have found the earlier reference to deceit too strong, but it was not. At length, the draft bill must somehow directly confront the present law which outlaws euthanasia. So, the doctor is required by the bills to certify the death as due to the underlying illness, that is, to lie (though falsifying a death certificate is currently a punishable offence), and the death is not to be regarded, *for the purposes of the Act*, as any form of homicide, even though it was unquestionably homicide. Truth must yield to weasel words for these bills to succeed.

After euthanasia, the doctor may not be subject to any civil or criminal action, nor to any penalty or loss

of privilege by any professional body. With only a few exceptions, medical associations throughout the world hold that euthanasia is forbidden to doctors because it is unethical, that is, morally wrong. Australian state governments establish boards and tribunals to regulate medical practice and they all regard medical life-taking as deserving of deregistration because those doctors are no longer fit to practise, on ethical grounds. These clauses in the bills are included without the consent or authority of the regulators, who regard them as necessary to protect patients against attacks on their lives, in recognition of their genuine human rights. Just now, when it is being more widely recognised that there is a need for more emphasis on ethics in many areas of moral significance, the supporters of euthanasia want to dispense with them altogether. It may be wondered

what benefits the community can expect to gain from having unethical doctors.

When all euthanasia draft bills so far put before state parliaments over many years are reviewed, it can be observed that they go to extreme lengths to shield the doctor from the effects of current law, no matter what he or she may have done negligently or by omission, while including many opportunities for endangering the lives of patients who did not want their life ended. In justice, it is the vulnerable who need protection, not the powerful. This danger is exactly what all the large committees of inquiry into the consequences of

legalising euthanasia have predicted in their published reports, even those which included some members who were in favour of euthanasia. No other reasoned conclusion was available to them after extensive oral and written evidence had been taken from a wide range of community and professional sources. Every law to permit euthanasia will be inherently and unavoidably unsafe.

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